R3P27-1F

Teenage Pregnancy and Too-Early Childbearing:

Public Costs, Personal Consequences

Center for Population Options

CPO's National Priorities List for Reducing Teen Pregnancy & Too-Early Childbearing

1) National leadership, with federal and Executive commitment to the health of children and youth and to adequate sex education and family planning services for all.

2) Increased federal and state funding for family planning and teenage pregnancy prevention programs.

3) K-12 Family Life Education, incorporating life skills, self-esteem building, sexuality education, including information on the prevention of pregnancy and sexually transmitted disease, life planning, and vocational skills. Family Life Education should give young people the skills and self-confidence to delay intercourse and childbearing.

4) Affordable and accessible health care for youth through community health clinics that accommodate the needs of youth or through school-based health clinics.

5) Coordinated community efforts to provide education, services, and options for hard-to-reach or at-risk youth.

6) Low-cost, accessible contraceptive options for sexually active youth.

7) Cooperative ventures among private and public agencies to offer vocational planning, job skills, and economic opportunities to teenagers.

8) Safe, affordable, accessible abortion services for teenagers with unintended and unwanted pregnancies who choose not to continue the pregnancy.

9) Public education, outreach, pre- and post-natal services for pregnant teenagers who choose to carry a pregnancy to term, including programs to help parenting teens remain in school.

10) Television and other media advertising of contraceptives and prophylactics for the prevention of pregnancy and sexually transmitted disease.

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Introduction

Why do we worry about teenage pregnancy? Teenage pregnancies themselves don't have a quantifiable public cost, except perhaps for some pre-natal care. Today what is most disturbing about teenage pregnancy and too-early childbearing is the cycle of poverty and economic dependence that so often begins with an early birth. It is the negative outcomes of unintended and unwanted pregnancies that we are concerned with -- outcomes that frequently involve low birthweight babies who need extended hospital care, single parenthood for women and subsequent reliance on public support, and truncated education because the parent or parents drop out of high school to take care of a child and so have a lower earning potential in the job market.

Teenage childbearing has contributed to and reflects the changing face of the American family. It contributes to a devastating high-school drop-out rate, to the swelling numbers of single mothers in the U.S., and to the extraordinary numbers of children living in poverty. It has ominous implications due to the connection between teenage sexual practices and the risk of HIV infection and AIDS, and it has swelled the ranks of homeless, drug-addicted babies in public hospitals, dubbed "boarder babies" because so few are adopted. It is an agonizingly stubborn public health problem -- the more so because it is a preventable one -- that has defied solution for decades, and it is one that promises to worsen dramatically as reproductive options for pregnant teenagers are constrained.

The costs continue to rise. This study focuses on the quantifiable economic impact of teenage pregnancy, a measure of what it costs the country each year in taxpayer dollars to support families that began when the mother was a teenager. These numbers are important for understanding the trade-off between what is spent on prevention and what we must allocate after prevention efforts have proven themselves insufficient.

Across the country, a wide variety of programs have been successful with groups of teens in limited settings. But significantly reducing teen pregnancy, we have learned, cannot be accomplished with a single program or a single approach. Rather, the problem requires a wide net of programs and services together with the active involvement of a broad cross-section of the community from policy-makers to parents. Most important, reducing teenage pregnancy cannot occur without first improving access to sexuality information and family planning services for all adolescents.

Teenagers must have direct and accurate information about sexuality, including support to delay sexual activity, as well as access to convenient, confidential, and affordable family planning counseling and medical services. Teenagers must perceive real options for their futures in order to be motivated to avoid premature childbearing, and so must have access to both quality education and vocational opportunities. They must, above all, be given incentives to seek professional health care if they become sexually active so that unwanted pregnancy and sexually transmitted diseases are prevented. Schools, youth serving agencies, youth employment organizations, clinics, policy-makers, corporations, and religious organizations must come together to make all this a reality and to help teenagers plan secure, productive futures.

1988 Estimated Costs of Teenage Childbearing

For the past four years, CPO's "Estimates of Public Costs for Teenage Childbearing" has highlighted the impact of adolescent births on the nation's budget. Three different sets of public costs are calculated. The first, known as "Single Year Costs," shows how much the U.S. spends as a result of teenage childbearing in a given year. The total public outlay includes expenses for all families in which the first birth occurred when the mother was a teenager, even though the mother may now be considerably older. Figures are based on Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamp payments, and the percentage of those expenditures that go each year to families that began when the mother was in her teens.

In 1988, the U.S. Single Year Cost was $19.83 billion dollars, an increase of $560 million from 1987 (Tables I & IV). The figure, which includes direct payments to service providers as well as the administrative costs of the programs listed, is a conservative estimate: it does not include other public costs commonly associated with family support such as housing subsidies, special education, foster care, or day care. If every birth to a teen mother had been delayed, the U.S. would have saved 40% of that amount, or $7.93 billion. The increase in costs from 1987 is almost entirely due to the rate of inflation, reflecting a steady teenage birthrate in the year 1987-88, and suggesting little change in teenage pregnancy rates and minimal change in pregnancy prevention efforts. The 1988 single year cost is more than $3 billion higher than in 1985 (Table IV).

The second set of figures, Single Birth Cost, reflects the public cost over a projected twenty year period for a single family begun in 1988 by a teen birth. This is the average public cost for one family over the first twenty years of the child's life. A family begun by a first birth to a teenage mother in 1988 will cost the taxpayer approximately $16,410 by the time that baby reaches age twenty (Table II). This number may appear low because it represents an average across all first births to teens even though only one-third of families begun with a teen birth actually receive public assistance. The actual amount going to a family that receives public assistance after a teen birth would be approximately $49,230 over 20 years. There were 364,587 first births to teens in 1988, almost 10,000 of those to girls age 14 and younger.

Finally, the study measures the cost for <u>all</u> teen families begun in 1988 over the following twenty years, and we call this the Single Cohort Cost. This figure represents what the U.S. will spend to support all the families begun in 1988 by a teen mother over the next twenty years. The

Single Cohort Cost for 1988 is $5.98 billion (Table III). This cost has risen by almost a billion dollars since 1985 (Table VI). If those 1988 births had been delayed, CPO estimates a potential saving of well over two billion dollars -- many times most state social welfare budgets in any given year and 42 times as much as the U.S. spent for family planning services in the same year.

1988 SINGLE YEAR COST

TABLE I

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births

Estimate for 1988 (in billions)

Funding Source	Total Outlay for AFDC Recipients#	Outlay Attributable To Teenage Childbearing*	Potential Savings†
Aid to Families with Dependent Children (AFDC)	$18.99	$10.07	$ 4.03
Food Stamps	$ 5.45	$ 3.23	$ 1.29
Medicaid	$11.73	$ 6.53	$ 2.61
TOTAL		**$19.83 BILLION**	**$ 7.93 BILLION**

Includes administrative costs.

* Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.[1] See Methodology for further explanation.

† Calculated at 40 percent of full cost.[2]

1988 SINGLE BIRTH COST

TABLE II

Projected 20-Year Cost to Support Each Family Begun by a Teenager in 1988 and Potential Savings Associated with Delaying These Births#

Estimates over Twenty-Year Period 1988-2007

Age	Number of First Births^	Average Single Family Cost*	Potential Savings†
<15	9,966	$20,723	$ 8,289
15-17	149,170	$20,679	$ 8,272
18-19	205,451	$13,101	$ 5,240
Teenagers all ages	364,587	$16,410	$ 6,564

1988 SINGLE COHORT COST

TABLE III

Projected 20-Year Public Cost for All Families Started by Teenagers in 1988 and Potential Savings Associated with Delaying These Births#

Estimates over Twenty-Year Period 1988-2007 (in billions)

Age	Full Cost*	Potential Savings†
<15	$0.21	$0.08
15-17	$3.08	$1.23
18-19	$2.69	$1.08
all teens	**$5.98 BILLION**	**$2.39 BILLION**

#Based on AFDC, Medicaid and Food Stamp expenditures.

^1987 natality statistics are the latest available. Monthly Vital Statistics Report, "Advance Report of Final Natality Statistics, 1987," 38:3, June 29, 1989, Table 2, p. 16.

*Cost is expressed in 1988 "present value" dollars, which means that this is the amount that would have to be set aside in 1988 to cover the 20 year cost of the average family begun by a first birth to a teen in 1988, after taking into consideration inflation and the future earning power of a dollar invested in 1988. For Table III, "full cost" represents the total cost to support ALL of the 364,587 families, begun by a first birth to a teenager in 1988, at the average costs estimated in Table II. See Methodology for further explanation.

†Calculated at 40 percent of full cost. See reference 1.

FOUR YEAR TRENDS

TABLE IV

Four Year Trend in Single Year Costs Attributable to Teenage Childbearing

Estimates for 1985-1988 (in billions)

SINGLE YEAR COST:	1985	1986	1987	1988
	$16.65	$17.93	$19.27	$19.83

TABLE V

Four Year Trend in Projected 20-Year Public Costs to Support Each Family Begun by A Teen Birth.

Estimates for 1985-1988 (average cost)

Age	1985	1986	1987	1988
<15	$17,724	$18,913	$19,691	$20,723
15-17	$17,689	$18,897	$19,638	$20,679
17-19	$11,214	$11,984	$12,416	$13,101
Teenagers all ages	$13,902	$14,852	$15,450	$16,410

TABLE VI

Four Year Trend in Projected 20-Year Costs to Support All Families Begun by a Teen

Estimates for 1985-1988 (in billions)

Age	1985	1986	1987	1988
<15	$0.17	$0.18	$0.19	$0.21
15-17	$2.55	$2.73	$2.85	$3.08
17-19	$2.44	$2.60	$2.66	$2.69
all teens	$5.16	$5.51	$5.70	$5.98

Public Costs: The Case for Teen Pregnancy Prevention

The public costs of teenage childbearing dramatize in stark financial terms the outcome of a failure to prevent teenage pregnancies, a failure that is increasing public costs by hundreds of millions of dollars each year. And these increases do not begin to meet the need of poor families for assistance. As homelessness worsens, and half of all black children live in poverty, we receive daily reminders that the assistance we provide is not reaching everyone who needs it, and it is not meeting even the basic needs of some who do receive it. And yet the numbers of teenage pregnancies continue at a steady annual level, and we continue to fail our young people on both sides of the parenting decision.

The public costs of teenage childbearing, taken in that light, also give a chilling outline of future costs if prevention is not addressed and if access to legal abortion is constrained or denied. Today, fewer than half of the teenagers who become pregnant choose to continue the pregnancy. One cannot ignore the implications of the government insisting that 400,000 more teenagers give birth to unplanned babies each year.

There is little dispute that teenage pregnancy increases dramatically a woman's chances of living in poverty, which in turn increases the chance of her children becoming teenage parents and living in poverty. Welfare support and other public programs are necessary to help these young families, but studies have shown that if the pregnancies were delayed by just a few years the chance of a woman's depending on welfare goes down substantially.[3]

According to the National Longitudinal Survey of Young Women, for each year a first birth is delayed, family income at age 27 increases by almost $500. The woman's individual income is raised by $200. What's more, delaying a birth just until age 18 or 19 raises potential family income by close to $700. This means that for each year a first birth is delayed (until age 20), a woman's chance of living in a family below the poverty level is reduced by about 22 percent. [4]

More than one million teenagers become pregnant every year in the United States.[5] Three-quarters of these pregnancies are unintended; 92% of pregnancies to unmarried teenagers are unintended.[6] The health, social, and economic consequences of teenage pregnancy are almost all negative. And those unintended pregnancies that result in the birth of a child have the most obvious negative consequences and are of the most concern.

Most teenagers -- girls and boys -- are not prepared for the physical, social, and economic challenges parenthood requires, yet almost half of the teenagers who become pregnant will carry their pregnancies to term.[7] Of those who give birth, 96 percent will keep and try to raise their child.[8] These numbers are even more disturbing when one considers that women under 18 who continue a pregnancy are more likely to develop medical complications than those who delay childbearing until later.[9]

Moreover, because many teenagers do not seek pre-natal care during the first trimester of a pregnancy, their babies suffer disproportionately from low birthweight and other perinatal conditions that make them much more likely (in fact, almost twice as likely) to die in the first year of life than babies born to mothers over age 20.[10] Infant morbidity -- an extreme state of ill health, often leading to death -- is not only a personal tragedy, it is an economic burden to a family and to society as well.

What are the factors that lead teen parents into the cycle of poverty, or at least into reliance on some public support? The first is the effect of teenage pregnancy on education. It is no surprise that because of the time required to raise a child, when a teenager has a baby the time normally spent on studying and going to school is superseded by the need to attend to the child. A 1983 survey of 20- to 26-year-old women reported that 95% of childless women completed high school requirements, while only 53% of those who had given birth within seven months of leaving school had done so.[11] Today, pregnancy is the leading cause of female school drop-out in the country.[12] Research has repeatedly demonstrated that women who bear children as teenagers and drop out of high school are substantially less likely ever to go back to school and complete their education than those who delay parenthood until after high school.[13]

It is true that for a number of reasons women who bear children as teens today are completing more schooling on average than their counterparts in the late 1960's, but the effect is diminished because all teens are staying in school longer, whether or not they become parents . Title IX of the 1972 Education Amendments, implemented in 1975, prohibits public schools from discriminating against pregnant and parenting students, a law which has allowed many more girls to finish their educations. However, a study in 1982 suggested that the increase in schooling for teen mothers has not

boosted their earning power enough to prevent their reliance on public assistance.[14] And although some girls who enroll in special programs for pregnant teens have fared far better in later life than those who stayed in a regular school program or those who dropped out, teen mothers on average do not fare as well financially as non-parenting teenage girls.[15]

The generally high number of children in families begun by teenagers also has an impact on the need for public support. Women who have children early have more children more rapidly than those who delay childbearing.[16] It has also been shown that many teenage mothers continue to have unintended pregnancies, whether due to inadequate contraceptive use or a generalized failure to plan childbearing.[17] Each child born to a teenage mother adds significant costs in terms of public support over the early lifetime of the child.

Combined, the effects on education and the number of children in the family dramatically affect the earning potential of families begun when the mother was under 20 years old and contribute to the fact that more than 50 percent of all AFDC recipients had their first child in their teens.[18]

A renewed national commitment to adequate health and family planning services is only the first step toward preventing too-early childbearing. To save money, reduce teenage dependence on public welfare, and help teens build their futures by choice instead of by accident, programs must be made available or strengthened that will help teens delay their first pregnancy, combined with adequate access to health care for pregnant teens who choose to bear a child, or safe, legal abortion for teenagers who choose to terminate a pregnancy. Only with such a focused national commitment can we hope to help teens delay childbearing beyond adolescence and break the spiral of public costs and private despair.

Methodology

Calculating the Costs

The costs of teenage childbearing can be conceptualized in three different ways. The first is in terms of expenditures in a given year: single year cost. This figure answers the question: "In 1988, how much did the federal government spend on families begun when the mothers were teenagers?" This includes public outlays for families currently headed by teenage mothers and also those in which the mother is now 20 years of age or older, but had her first child when she was still in her teens. Although the vast majority of AFDC families have a single, female head-of-household, CPO calculations do not distinguish between married and unmarried teen mothers.

CPO includes three forms of public assistance in the calculation of these costs: Aid for Families with Dependent Children (AFDC), Medicaid, and Food Stamps. The dollar value includes both direct payments to individuals, as well as the administrative and service costs of these programs. Costs of social service programs for young mothers, special education, foster care, and public housing subsidies are not included in the single year cost. Though some of these expenditures are clearly attributable to teenage childbearing, estimating the dollar amounts on a national level for all families begun by a teen birth is not feasible. These expenditures are more readily available for a given year and are factored in to the single birth and single cohort costs.

The second type of cost is the projected cost over 20 years of a single teen birth in a given year: single birth costs. This figure answers the question: "How much will a family begun in 1988 by a teen birth cost the public by the time that first baby is twenty years old?" This number may appear low because it is an average cost based on the total number of first births to all teen mothers in 1988. Because approximately one-third of teenage mothers receive public assistance, the actual cost for a family requiring public assistance and begun by a teen birth in 1988 will be about three times this estimated average cost.

The single birth costs are adjusted to reflect two important trends. First, the probability of receiving public assistance decreases over a teen mother's lifetime. The probability that a teen mother will receive welfare is one in three (.34), and the average length of time a woman who begins her family as a teen receives that assistance is 2.5 years. By the time a teen mother is 30 years old, the probability that she will still be receiving public assistance decreases to less than three in one hundred (.03).

Second, those who begin childbearing earlier in their teen years are likely to have more children than those who delay childbearing. Teens who have their first child before age 18 will have, on average, 3.2 children by age 32. Those who delay until they are 18 or 19 years old will have an average of 2.8 children by the time they reach age 32. These estimates are important in projecting the number of family members eligible for benefits and future medical expenses associated with pregnancy and childbearing.

The third type of cost calculated is the projected 20-year cost of all first children born to teens in a given year: single cohort costs. In this case we are answering the question, "How much will all the families begun by a teen birth in 1988 cost by the time those first babies are twenty years old?" This is calculated by multiplying the single birth costs for 1988 by the total number of first births to teens in that year. For both single birth cost and single cohort cost estimates, social service and public housing costs are included, in addition to AFDC, Medicaid, and food stamp costs used to calculate single year costs.

For all the public costs calculated, an estimate is made of the potential savings to the public had there been no births to teenagers in 1988, or in other words, what we might still expect to spend had all those teen births been prevented. The potential savings are lower than the public costs in each case because delaying childbearing until age 20 or more does not guarantee that a woman will never need to receive public assistance. Because many of the women who become teenage mothers are already at a higher risk of needing financial assistance as an adult, many of the costs included in these calculations would be reduced by eliminating teenage births, but they could not be wiped out entirely.

Previous research into public costs of teenage childbearing estimated a saving rate of 20% for reducing teenage births by half.[19] Thus, CPO determines potential savings for delaying 100% of teen births by figuring 40% of the calculated public costs.[20]

Determining Public Outlays†

The cost of AFDC payments attributable to families begun by teen births is calculated as 53% of the total AFDC payments made in 1988. This estimate is based on extensive computer simulations, with a variety of databases, that resulted in a range of 50% - 56% of total AFDC expenditures. CPO settled on the midpoint of 53% for the purposes of this study, allowing for the possibility that the actual amount may be very slightly higher or lower. Administrative costs are estimated at 12% of direct costs, based on national averages over a five-year time period.

Medicaid payments are determined from the average payments for adults and children and the average numbers of adults and children receiving these payments because of their AFDC eligibility, multiplied by 53%. Administrative costs for Medicaid are calculated as 5% of the direct payments, again based on national averages over a five-year time period.

Food stamp costs are determined from the average monthly payment (multiplied by 12) and the average numbers of adults and children receiving food stamps, multiplied by 53%. Administrative costs for food stamps are estimated as 12% of direct costs.

For single birth and single cohort costs, both married and unmarried teens experiencing a first birth in 1988 are included. A teen mother who is married has a higher probability of needing public assistance during the first twenty years of her child's life than does a married teen who delays childbearing until she is 20 or more years old.

CPO focused on teens having first births because the first teen birth often triggers a sequence of events necessitating public assistance. Subsequent births are accounted for in the 53% calculation of welfare families begun by a teen birth and in the calculation of single birth and single cohort costs that include costs over a 20-year period. In considering costs over the next 20 years, it should also be noted that these costs are discounted at a rate of 4%. This assumes that a dollar invested in 1988 will grow at an interest rate of 4% (after inflation) per year, compounded annually.

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† See also section on Sources of Data, p. 14.

Sources of Data for the 1988 Cost Study

Single Year Public Costs Estimates

AFDC Expenditures: $16,645,000,000 in AFDC direct cash grants, Fiscal Year (FY) 1988.[21] Administrative costs of $2,352,700,000 added for total AFDC expenditures.[22]

Food Stamp Expenditures: $49.80 average monthly Food Stamp payment per individual in FY 1988.[23] Multiplied by 10,920,275, the average monthly number of adults and children receiving AFDC in FY 1988.[24] Adjusted for an 83.5 percent participation rate of AFCD households in the food stamp program.[25] Administrative expenses of 12 percent added.[26]

Medicaid Expenditures: 5,503,317 AFDC adults and 10,037,347 AFDC children received a total of $5,882,749,912 (to adults) plus $5,847,852,317 (to children) during FY 1988.[27] Administrative expenses of 5 percent were added based on recent actual experience.[28]

Single Birth and Single Cohort Public Costs Estimates

AFDC Cost: An average payment of $127 per recipient per month in FY 1988.[29] AFDC benefits are adjusted at a rate of 3.2 percent per year to account for inflation and discounting.[30]

Food Stamp Cost: $49.80 average payment per recipient per month in 1988.[31] For the years following 1988, the per recipient cost was reduced by 3 percent per year (5 percent inflation minus 2 percent increase in food stamp allocation). All adjusted for a 83.5 percent participation rate of AFDC households in the food stamp program.[32] Administrative costs of 12 percent added.[33]

Annual Medicaid Cost: On average each AFDC child cost Medicaid $583 in FY 1988, while each adult cost Medicaid $1,069.[34] These numbers remain constant for the 20-year projections because costs will keep pace with inflation.

First Births: In 1987 there were 9,966 births to girls under 15; 149,170 births to 15-17 year-olds, and 205,451 births to 17-19 year-olds. 1987 natality statistics were used, as these are the latest available.[35]

Medicaid Costs Associated with Births: These calculations used $3,494 as the cost borne by Medicaid (including prenatal care costs) for a birth to a teenager 14 or younger; $3,224 as the cost for 15-17 year-olds, and $2,696 as the cost for 18-19 year-olds. These figures are the average costs estimated by three different studies: Walentik,[36] Wertheimer and Moore,[37] and Burt et al.,[38] adjusted for inflation at 4 percent per year since 1985.

Social Service Cost: Assumed to be 5 percent of AFDC cost, following Walentik's logic and example.[39]

Public Housing Cost: Assumed to be 2 percent of AFDC cost, following Walentik's and SRI International's examples.[40]

AFDC, Food Stamp and Medicaid Administrative Costs: AFDC administrative costs of $2,352,700,000.[41] Food Stamp administrative costs calculated using 12 percent of direct benefits, based on historical precedent.[42] Medicaid administrative costs calculated at 5 percent of benefits, also based on historical precedent.[43]

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Costs to the Federal Government and Selected States and Cities.

the Center for Population Options

CPO's National Priorities List for Reducing Teen Pregnancy & Too-Early Childbearing

1) National leadership from Congress and the Executive Branch to improve the health of children and youth and to provide adequate sex education and family planning services for all.

2) Increased federal and state funding for family planning and teenage pregnancy prevention programs.

3) K-12 Family Life Education, incorporating life skills, self-esteem building, sexuality education, including information on the prevention of pregnancy and sexually transmitted disease, and life planning. Family Life Education should give young people the skills and self-confidence to delay intercourse and childbearing.

4) Affordable health care for youth through community health clinics that accomodate the needs of youth or through school-based clinics.

5) Coordinated community efforts to provide education, services, and options for hard-to-reach or at-risk youth.

6) Effective, low-cost contraceptives accessible to sexually active youth.

7) Cooperative ventures among private and public agencies to offer vocational planning, job skills, and economic opportunities to teenagers.

8) Safe, affordable, accessible abortion services for teenagers with unintended and unwanted pregnancies who choose not to continue the pregnancy.

9) Education, outreach and pre- and post-natal services for pregnant teenagers who choose to carry a pregnancy to term, including programs to help parenting teens remain in school.

10) Television and other media advertising of contraceptives and prophylactics for the prevention of pregnancy and sexually transmitted diseases.

Credits

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1. Introduction

For the first time in almost two decades, the birth rate among teenagers in the United States is rising. In 1988, 488,961 teenagers gave birth, accounting for 12.5 percent of all births. Almost one-quarter of these births were to adolescents who already had one or more children. The increase in birth rates was sharpest among young teens, ages 15 to 17—10 percent in the span of two years.[1] For policy-makers and the public, these numbers are dismaying. For the thousands of teenage girls becoming mothers too soon, they are devastating.

Teenage pregnancy exacts costs far beyond those incurred by the federal and state governments to support families begun by a teen birth. Too-early childbearing often impoverishes lives—the lives of girls brought too soon into the rigors and responsibilities of motherhood, of boys bewildered and unable to parent and provide adequately, of babies not planned or welcomed who become children blighted by lasting disadvantages in life. It places a heavy burden on families and communities and contributes to our country's unconscionably high rates of low birthweight and neonatal mortality.

After an 18-year decline, the jump in teen birth rates is stark evidence that, as a nation, we are failing our youth. We have failed to provide adequate and early sex education, failed to ensure access to safe and confidential reproductive health care, including the provision of birth control, and failed to give adolescents reasons to delay childbearing and parenting until they have received the education and skills they need to build secure, productive futures for themselves and their families. The United States has the highest teen pregnancy rate of all developed countries, almost twice that of England, France and Canada, and more than six times that of the Netherlands.[2] More than a million girls become pregnant in this country every year; almost half of them give birth.[3]

Too often, both these teenage parents and their children face a horizon of limited educational and economic opportunities. Too-early childbearing can initiate a cycle of incomplete education leading to poverty and economic dependence. With less education and job experience, teen mothers are often consigned to a lower earning capacity. Teen mothers are less likely ever to complete high school and more likely to receive public assistance than their peers who delay childbearing. Moreover, the children of adolescent mothers, often growing up in single-parent households and in poverty, suffer high rates of school failure and behavioral problems.[4]

Since 1986, this study has focused on the quantifiable economic impact of teenage pregnancy, a measure of what it costs the country each year in taxpayer dollars to support families begun when the mother was a teenager. This year the cost study has been expanded to include estimates for five states and two cities, representative of different regions around the country. The states–Vermont, Louisiana, Wisconsin, New Mexico and Oregon–and the cities–Baltimore and St. Louis–reveal a broad range of costs for the different locales they represent. The figures for each state and city, as well as a discussion of teenage pregnancy and prevention efforts in each area, are included in Section 3.

The numbers, both federal and local, often seem uncomfortably large. Yet they may in fact be too small to provide adequately for new mothers and their children with no other sources of support. To fail to provide this support is to invite both greater health and welfare problems and more costs later. It is important that we understand the trade-off between what is spent on prevention and what we must allocate after prevention efforts have proven themselves insufficient.

When the overwhelming majority of teen pregnancies are unintended, it is clear that prevention efforts are necessary. Along with the rising teen birth rate, the numbers reported in this study should give us pause. It is high time to reassess the strategies of the last decade. Teenagers need sexuality education that is both accurate and comprehensive in its discussion of birth control options, including abstinence. They need confidential access to family planning services and reproductive health care. And they need all this both before and after they become sexually active.

Reducing the rates of too-early childbearing in this country is within our reach. Education is one key to prevention; access to services is another. So too is a commitment to ensuring that all teenagers have real options for their futures. By refusing to take these steps, we turn our backs on our youth and the future, both theirs and ours.

2. Estimated Costs of Teenage Childbearing for Fiscal Year 1989

For the past five years, CPO's "Estimates of Public Costs for Teenage Childbearing" has highlighted the impact of adolescent births on the nation's budget. This year's cost study focuses on two surprises. The first, a rise in teen birth rates, is discouraging. The second, a greater than expected increase in the costs of teen pregnancy, ironically reflects a more encouraging development: an expansion of Medicaid coverage for low-income pregnant women and children under age six.

Three different sets of public costs are estimated. The first, known as "Single Year Costs," shows how much the U.S. spends as a result of teenage childbearing in a given year. The total public outlay includes expenses for all families in which the first birth occurred when the mother was a teenager, even though the mother may now be considerably older. Figures are based on the percentage of expenditures in three major support programs—Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamp payments—that go each year to families that began when the mother was in her teens .

In 1989, the U.S. Single Year Cost was $21.55 billion, an increase of $1.72 billion from 1988 (Tables I & IV). The figure, which includes direct payments to service providers as well as the administrative costs of the programs listed, is a conservative estimate: it does not include other public costs commonly associated with family support such as housing subsidies, special education, foster care, or day care. If every birth to a teen mother had been delayed until the mother was in her 20s, the U.S. would have saved 40 percent of that amount, or $8.62 billion.

The increase in costs from 1988 is due in part to the rate of inflation. However, it is due in larger part to a number of other factors: an increase in births to teenagers in 1988-89, and an expansion of Medicaid coverage for pregnant women and children under age six. By April 1990 all states were required to expand Medicaid eligibility to all pregnant women and children up to age six with family incomes below 133 percent of the federal poverty level. More than one-third of the states have gone a step further, expanding eligibility for pregnant women and infants with family incomes up to 185 percent of the federal poverty level. Expanded coverage may help more women to get adequate prenatal care—ensuring more healthy pregnancies and births—and to keep their children healthy. Moreover, preventive care can help reduce costs later. Viewed in this light, the increase is welcome.

The second set of figures, Single Birth Costs, reflects the public cost over a projected twenty year period for a single family begun in 1989 by a teen birth. This is the average public cost for one family over the first twenty years of the child's life. A family begun by a first birth to a teenage mother in 1989 will cost the taxpayer approximately $16,975 by the time that baby reaches age twenty (Table II). This number may appear low because it represents an average across all first births to teens even though only one-third of families begun with a teen birth actually receive public assistance. A more realistic average amount to each family that receives public assistance after a teen birth would be approximately $50,925 over 20 years. There were 374,307 first births to teens in 1988, over 10,000 of those to girls age 14 and younger.[5]

Finally, the study estimates the cost of all teen families begun in 1989 over the following twenty years—the Single Cohort Cost. This figure represents what the U.S. will spend over the next twenty years to support all the families begun in 1989 by a teen mother. The single cohort cost for 1989 is $6.35 billion (Table III). This cost has risen by over a billion dollars since 1985 (Table VI). If those 1989 births had been delayed, CPO estimates a potential savings of over $2.54 billion – many times most state social welfare budgets in any given year and almost 20 times as much as the U.S. spent for family planning services in 1989.*

*In fiscal year 1989, $135.10 million was available for Title X, the only federal program directed specifically for family planning services.

1989 Single Year Cost

TABLE I

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births

Estimate for 1989

(in billions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)	$19.68	$10.43	$ 4.17
Food Stamps	$ 5.79	$ 3.44	$1.38
Medicaid	$14.17	$7.68	$3.07
TOTAL		**$21.55**	**$8.62**

[a]Includes administrative costs.

[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.[6] See Methodology for further explanation.

[c]Calculated at 40 percent of full cost.[7]

1989 Single Birth Cost

TABLE II

Projected Average 20-Year Cost to Support Each Family Begun by a Teenager in 1989 and Potential Savings Associated with Delaying These Births[a]

Estimates over Twenty-Year Period 1989-2008

Age	Number of First Births[b]	Family Cost[c]	Average Single Potential Savings[d]
<15	10,234	$21,491	$8,594
15-17	151,280	$21,446	$8,579
18-19	212,793	$13,579	$5,431
All Teens	374,307	$16,975	$6,790

[a]Based on AFDC, Medicaid and Food Stamp expenditures.

[b]1988 natality statistics are the latest available.[a]

[c]Cost is expressed in 1989 "present value" dollars, which means that this is the amount that would have to be set aside in 1989 to cover the 20-year cost of the average family begun by a first birth to a teen in 1989, after taking into consideration inflation and the future earning power of a dollar invested in 1989. For Table III, "full cost" represents the total cost to support ALL of the 374,307 families begun by a first birth to a teenager in 1989 (estimate based on 1988 statistics), at the average costs estimated in Table II. See Methodology for further explanation.

[d]Calculated at 40 percent of full cost.[3]

1989 Single Cohort Cost

TABLE III

Projected 20-Year Public Cost for All Families Begun by Teenagers in 1989 and Potential Savings Associated with Delaying These Births[a]

Estimates over Twenty-Year Period 1989-2008

(in billions)

Age	Full Cost[c]	Potential Savings[d]
<15	$0.22	$0.09
15-17	$3.24	$1.30
18-19	$2.89	$1.15
All Teens	$6.35	$2.54

[a]Based on AFDC, Medicaid and Food Stamp expenditures.

[c]Cost is expressed in 1989 "present value" dollars, which means that this is the amount that would have to be set aside in 1989 to cover the 20-year cost of the average family begun by a first birth to a teen in 1989, after taking into consideration inflation and the future earning power of a dollar invested in 1989. For Table III, "full cost" represents the total cost to support ALL of the 374,307 families begun by a first birth to a teenager in 1989 (estimate based on 1988 statistics), at the average costs estimated in Table II. See Methodology for further explanation.

[d]Calculated at 40 percent of full cost.[9]

Five Year Trends

TABLE IV

Five Year Trend in Single Year Costs Attributable to Teenage Childbearing

Estimates for 1985-1989

(in billions)

SINGLE YEAR COST:	1985	1986	1987	1988	1989
	$16.65	$17.93	$19.27	$19.83	$21.55

TABLE V

Five Year Trend in Projected 20-Year Public Costs to Support Each Family Begun by a Teen Birth

Estimates for 1985-1989

(average cost)

Age	1985	1986	1987	1988	1989
<15	$17,724	$18,913	$19,691	$20,723	$21,491
15-17	$17,689	$18,897	$19,638	$20,679	$21,446
18-19	$11,214	$11,984	$12,416	$13,101	$13,579
All Teens	**$13,902**	**$14,852**	**$15,450**	**$16,410**	**$16,975**

TABLE VI

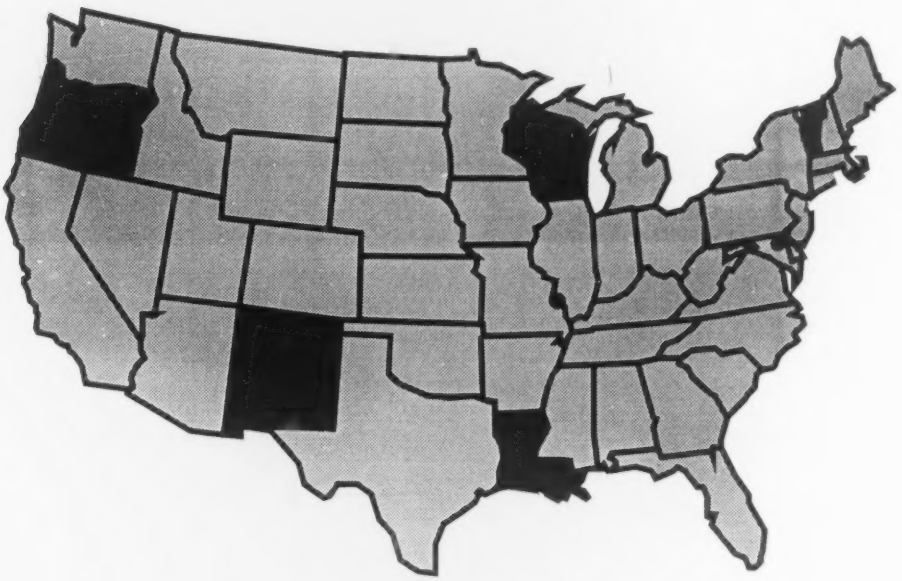
Five Year Trend in Projected 20-Year Costs to Support All Families Begun by a Teen

Estimates for 1985-1989

(in billions)

Age	1985	1986	1987	1988	1989
<15	$0.17	$0.18	$0.19	$0.21	$0.22
15-17	$2.55	$2.73	$2.85	$3.08	$3.24
18-19	$2.44	$2.60	$2.66	$2.69	$2.89
All Teens	**$5.16**	**$5.51**	**$5.70**	**$5.98**	**$6.35**

3. Teenage Childbearing: Five States and Two Cities



Teenage pregnancy exacts a toll on the local as well as the national level. This section includes cost estimates for Vermont, Louisiana, Wisconsin, New Mexico, Oregon, and Baltimore and St. Louis. The number we have calculated for each locale is an estimate of the Single Year Cost–the local equivalent of the $21.55 billion that the Federal government spends each year to support families begun when the mother was a teenager. This cost for the states and cities includes both what local governments spent on AFDC, food stamps and Medicaid and the portion of federal funding received by the states for these programs. Thus, the total figures for each state and city reported in this section represent both those jurisdictions' allocations of federal funds, part of the $21.55 billion described earlier, as well as other monies originating from state and local taxpayers.

Although these seven localities cannot represent all communities in the United States, they do provide an idea of the broad range of costs of too-early childbearing to states and cities. The brief descriptions of pregnancy prevention efforts in each area, while not meant to be comprehensive, paint a picture of the spectrum of approaches to reducing the incidence of too-early childbearing taken by states and cities.

Teenage Pregnancy In Vermont

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Vermont

Estimate for 1989

(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Familes with Dependent Children (AFDC)	$46.00	$24.38	$9.75
Food Stamps	$14.00	$7.42	$2.97
Medicaid	$12.98	$6.88	$2.75
TOTAL		**$38.68**	**$15.47**

[a]Includes administrative costs.

[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.[10] See Methodology for further explanation.

[c]Calculated at 40 percent of full cost.[11]

Among 15- to 19-year-old women in Vermont, the pregnancy rate is 82 per thousand; the birth rate for this group is 35 per thousand.[12] Although these rates are among the lowest in the nation, too-early childbearing remains a serious problem in Vermont. In 1987, only 49 percent of pregnant teens in Vermont received prenatal care beginning in the first trimester; 8.2 percent of the babies born to teens were born with a low birthweight.[13] And in Vermont, a single parent under 25 is nine times more likely to be poor than a young woman living on her own without children.[14]

With the formation of the Governor's Task Force for the Prevention of Teen Pregnancy in 1986, Vermont has made a concerted effort to address the problem of teen pregnancy. The latest report from the Task Force highlights a number of specific five-year goals: reducing the pregnancy and birth rates among 15- to 17-year-olds, reducing second and third births to teens, preventing all pregnancies to girls under 15, ensuring that all adolescents complete high school, ensuring that 90 percent of teens receive prenatal care beginning in their first trimester, and reducing low birthweight and infant mortality among babies born to teens. To achieve these goals, Vermont is working at both the grassroots and the state level. Communities throughout Vermont are encouraged to form Parent/Teen Forums and Teen Advisory Boards to identify and promote services for teens, to support the development of family life curricula, and to advocate for needed changes. Through public/private partnerships, many communitites have established Parent/Child Centers, which provide support, education and skills-training for adolescent parents.

At the state level, in order to better serve pregnant teens, a new case management system has been installed. Each pregnant teen is assigned a nurse, who makes sure that the teen receives prenatal and postpartum care, as well as any other services she needs. In 1988 the legislature passed an act requiring that all schools provide comprehensive health education—including information on contraception—to grades K-12. Vermont is also working to prevent school dropout and to improve youth employment and training programs.[15]

Teenage Pregnancy In Louisiana

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Louisiana

Estimate for 1989

(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Familes with Dependent Children (AFDC)	$206.67	$109.54	$43.81
Food Stamps	$140.08	$74.24	$29.70
Medicaid	$333.27	$176.63	$70.65
TOTAL		**$360.41**	**$144.16**

[a]Includes administrative costs.

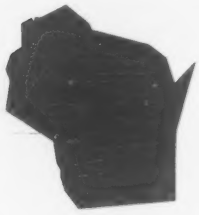
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.[16] See Methodology for further explanation.

[c]Calculated at 40 percent of full cost.[17]

The pregnancy rate in Louisiana is 109 per thousand 15- to 19-year-old girls, the 19th highest in the nation. The teenage birth rate, however, ranks the fourth highest: 71 per thousand among 15- to 19-year-olds.[18] Almost 17 percent of all babies born in Louisiana in 1988 were born to women age 19 and younger. In 1988, 12,376 adolescents gave birth in Louisiana. Thirty-six percent of these births were to teenagers age 17 and younger, and 9 percent were to girls age 15 and younger. More than a quarter of teens who gave birth already had one or more children.[19]

Louisiana has responded to teenage pregnancy both on a statewide and a local level. Two of Louisiana's largest parishes (counties) contain school-based health clinics. Sexuality education is provided in schools according to the mandate of local districts, with some state-legislated restrictions. A statewide family planning program offers specialized community-based services for adolescents and parents in two of eight state planning districts, with plans to expand into a third during FY 1991. Created by the state legislature in 1988, the Louisiana Adolescent Pregnancy Commission is developing a statewide comprehensive, coordinated plan to reduce significantly the incidence of teenage pregnancy and to provide needed educational, vocational, parenting, counseling and health services and programs for teenage parents.[20]

Teenage Pregnancy In Wisconsin



Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Wisconsin

Estimate for 1989

(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Familes with Dependent Children (AFDC)	$476.43	$252.51	$101
Food Stamps	$138.52	$73.42	$29.37
Medicaid	$211.12	$111.89	$44.76
TOTAL		**$437.82**	**$175.13**

[a]Includes administrative costs.

[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.[21] See Methodology for further explanation.

[c]Calculated at 40 percent of full cost.[22]

Among 15- to 19-year-old girls in Wisconsin, the pregnancy rate is 73 per thousand, a third less than the national rate.[23] The state reports a teen birth rate of 38 per thousand 15- to 19-year-old girls in 1988. In that year, teenagers accounted for 9.8 percent of all births in Wisconsin. There has been a steady increase in the percentage of total births to unmarried women in Wisconsin in the last two decades, as there has been for the nation as a whole. In Wisconsin as in the nation, teenagers comprise a disproportionate percentage of unmarried mothers.[24]

May 1990 witnessed the formation by the Wisconsin Legislative Council of a Special Committee on Teenage Pregnancy Prevention and Related Issues, directed to study the effectiveness of current programs, to determine whether better coordination between state, local and private programs is needed, and to formulate new approaches to reducing adolescent pregnancy in Wisconsin. Currently, programs to prevent teen pregnancy and to serve teen parents are administered through three state agencies. Family planning services, pregnancy prevention programs, pregnancy counseling services, and self-sufficiency programs for adolescent parents are among the programs supported by the Department of Health and Social Services.

The Adolescent Pregnancy Prevention and Pregnancy Services Board, created in 1985 by the legislature, awards grants to programs that provide health care, counseling, education, and vocational training to prevent teen pregnancy or to help parenting teens. Such programs include: school-based clinics, media campaigns, adoption counseling, residential facilities for pregnant teens, and adult role model programs for adolescents. Instruction in human growth and development, including information on sexuality, reproduction, contraception, and childbirth; interpersonal relationships; self-esteem and responsible decision-making; male responsibility; sex stereotypes, and family life, is under the purview of the Department of Public Information, as is the School Age Parents program, which provides parenting education and information on family planning and adoption services to pregnant and parenting teens. In addition, Wisconsin law requires the parents of a dependent minor to support the minor's child to the extent that she is unable to do so, until the minor parent reaches age 18.[25]

Teenage Pregnancy In New Mexico

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in New Mexico

Estimate for 1989

(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Familes with Dependent Children (AFDC)	$65.70	$34.82	$13.93
Food Stamps	$31.82	$16.87	$6.75
Medicaid	$54.19	$28.72	$11.49
TOTAL		**$80.41**	**$32.17**

[a]Includes administrative costs.

[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.[26] See Methodology for further explanation.

[c]Calculated at 40 percent of full cost.[27]

New Mexico's teen pregnancy rate of 116 per thousand 15- to 19-year-old girls ranks eleventh highest in the United States. Its birth rate of 70 per thousand ranks fifth in the nation.[28] In New Mexico in 1989, 5,645 women under age 20 became pregnant. Among the 4,281 teenagers who gave birth last year in New Mexico, almost a quarter delivered their second, third, fourth, or even fifth child. The infants of teenage mothers accounted for 17 percent of all neonatal deaths in New Mexico, reflecting a nationwide trend of lack of adequate prenatal care for pregnant teenagers.[29]

The state has tackled this problem from a number of different angles. New Mexico is among the 23 states which mandate that sexuality education be taught in all schools.[30] In 1988, the Governor established the Governor's Task Force on Adolescent Pregnancy to make policy and program recommendations to the Governor in areas such as community and school education, health and social services, and possible solutions to reduce teen pregnancy. The work of the Task Force resulted in the passage of four pieces of legislation addressing the problem of adolescent pregnancy. The first created the Office of the Coordinator of Adolescent Pregnancy Prevention. The Office serves as a liaison between local and state agencies and as a clearinghouse for information and activities. In addition, the Office allocates seed grants to both public and private enterprises and provides technical assistance in the development of teen pregnancy prevention programs.

The second and third acts provide funding for Alternative Education and Family Life Education programs; during FY 1989-90, eleven agencies received funding for these programs. The fourth bill funded a month-long statewide, multi-media campaign in February and March 1990 to educate both adolescents and adults about teenage pregnancy in New Mexico.[31]

Teenage Pregnancy In Oregon

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Oregon

Estimate for 1989

(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Familes with Dependent Children (AFDC)	$178.84	$107.30	$42.92
Food Stamps	$48.88	$29.33	$11.73
Medicaid	$62.17	$37.31	$14.92
TOTAL		**$173.94**	**$69.57**

[a]Includes administrative costs.

[b]Based on the assumption that families begun by a teen birth consume 60 percent of these funding sources.[32]

[c]Calculated at 40 percent of full cost.[33]

In Oregon, the teen pregnancy rate is 95 per thousand 15- to 19-year-old girls, somewhat lower than the rate for the U.S., which is 110 per thousand.[34] Between 7,500 and 8,000 teenage girls become pregnant each year in Oregon.[35] Among 15- to 19-year-old women, the birth rate is 42 per thousand.[36] Most of these teen parents are out of school and unemployed; over 60 percent of Oregon's welfare recipients began their families as teenagers.[37]

In 1989 the Oregon legislature established the Committee on Adolescent Pregnancy and Parenthood to study the problem of teen pregnancy and to make policy recommendations. The Committee released its first report in July 1990. The goals outlined in this report reflect a variety of concerns and approaches: ensuring that family planning services and information are available to adolescents in all areas of the state, developing comprehensive family life education programs, creating a public education initiative focused on adolescent childbearing, funding six pregnancy prevention pilot programs which replicate proven prevention models, and expanding school-based clinic programs. There are 13 SBCs currently in Oregon, with plans to open three more in fall 1990.

In addition, the Committee recommended ways in which parenting teens could be better helped by the state, including recognizing the cultural diversity among adolescent parents, building on the positive contributions of fathers and extended families, improving the quality and quantity of child care, and establishing a visitation program to promote healthy pregnancies for adolescents.[38]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Baltimore

Estimate for 1989

(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Familes with Dependent Children (AFDC)	$168.57	$118.00	$47.20
Food Stamps	$64.56	$45.19	$18.08
Medicaid	$118.40	$82.88	$33.15
TOTAL		**$246.07**	**$98.43**

[a]Includes administrative costs.

[b]Based on the assumption that families begun by a teen birth consume 70 percent of these funding sources.[39]

[c]Calculated at 40 percent of full cost.[40]

Baltimore has one of the highest teen pregnancy rates for a city of its size in the United States. 3,058 adolescents gave birth in 1989, accounting for 23 percent of all births in the city that year. The majority of these births (54 percent) were to 18- and 19-year-olds.[41] The pregnancy rate among this age group in Baltimore is 254 per thousand. Among teens ages 15 to 17, the pregnancy rate is 118 per thousand, and among 10- to 14-year-olds, it is 12 per thousand.[42]

Faced with a problem of this magnitude, Baltimore has responded with an array of strategies to reduce pregnancy and birth rates among its adolescents. The Office of Adolescent Pregnancy Prevention and Coordination develops and implements a comprehensive and coordinated plan of action aimed at addressing the complex health, education and social issues associated with teen pregnancy. In 1989, the OAPPC delineated five priority recommendations: strengthening both the current Family Life Education and Character Education programs, providing reproductive health services to all adolescents, male and female, sexually active and non-sexually active, establishing an effective mentor program, and providing after-school programs in middle schools. Many of Baltimore's programs stress the promotion of self-esteem and personal growth, emphasize education and skill development, and engage in outreach activities aimed at young men.

The Bureau of School and Adolescent Health Services administers nine school-based clinics in the city, as well as a unique "mall-based" medical center strategically located to serve the area with the highest teen pregnancy rate. The "Preparing Responsible Individuals" program, which contains a peer counseling component, strives to help young teens resist pressure to become sexually active. Finally, Baltimore's "Teen Enrichment Program" pays young women a dollar per day not to experience a repeat pregnancy. The program also provides educational and group interaction activities to 20 parenting teens as well as 20 teens who have never experienced a pregnancy. In 1989, its first year, the program met with encouraging success: only one girl in each group became pregnant.[43]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in St. Louis

Estimate for 1989

(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Familes with Dependent Children (AFDC)	$63.03	$33.40	$13.36
Food Stamps	$36.32	$19.26	$7.70
Medicaid	$53.84	$28.54	$11.42
TOTAL		**$81.19**	**$32.48**

[a]Includes administrative costs for Medicaid and food stamps. Administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources.[44] See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.[45]

In 1988 there were 1,745 births to women under the age of 20 in the city of St. Louis. 56 percent of these teen births were to 18- to 19-year-olds, 41 percent were to 15- to 17-year-olds, and 3 percent were to girls under 15. Mothers under the age of 20 accounted for one out of every five births in the city in 1988. Almost 11 percent of all babies born in St. Louis were born with a low birthweight; 60 percent were born to unwed mothers, of which a disproportionate number are teenagers.[46]

To address these problems, the city and county of St. Louis have created a number of programs. The Prevent Repeat Pregnancy Among Teens—PREPAT—program, begun in 1985 and administered by the St. Louis County Health Department, serves both city and county teens. PREPAT targets mothers under the age of 18. By making home visits, providing family planning services, and helping girls acquire the skills they need to plan careers, PREPAT strives to give young mothers the motivation to avoid a repeat pregnancy. Operation Childsave, a joint venture between the city and the county, was begun in response to the area's high infant mortality rates. Operation Childsave seeks to improve access to medical care for women of all ages; a large percentage of its clients are teens.

Since Missouri has no state-mandated sexuality education requirements, decisions about sex education are made by the individual school districts. Within the St. Louis region there is a wide range of sex education programs. In addition, several St. Louis schools participate in the state-run TeenAge Health Consultants (TAHC) program. Through the program, adolescent peer educators provide information to fellow students.[47]

4. Public Costs: The Case for Teen Pregnancy Prevention

As the numbers of births to teens and the costs of those births continue to grow, we see irrefutable evidence both of our failure to prevent teenage pregnancy and of the heavy toll–personal and public–of that failure. The rising teen birth rate signals that something is wrong. Any number of factors may contribute to higher rates of teen births; there may be more teen pregnancies or fewer abortions, or both. Since at this point only birth data are available for 1988, it is too early to see the picture clearly. What is certain is that more births will result in greater public costs. And deplorably even as costs rise, the needs of many poor families continue to go unmet: 48 percent of all children living in young families are growing up in poverty.[48]

With the proliferation of restrictive legislation, teenagers' reproductive options are increasingly constrained. The Supreme Court has demonstrated its willingness to allow states to erect barriers to reproductive health care for teens, and many states have done just that. Laws requiring parental consent or notification for adolescent abortion are already enforced in 13 states; the grim possibility of mandated parental consent for birth control services or treatment of sexually transmitted diseases looms on the horizon. If prevention is not addressed, and access to legal abortion is constrained or denied, future costs will only escalate. Today, almost half of the teenagers who become pregnant choose not to continue the pregnancy.[49] If access to legal abortion were denied, a recent study projects that at least 75,000 more teen births (an increase of 15 percent) would occur every year.[50] It is sobering to contemplate the consequences of further restrictions on adolescents' access to reproductive health care.

By providing health care services to adolescents before pregnancies occur, we **can** save significant costs later. A recent study from the Alan Guttmacher Institute found that for every dollar of federal funds spent to provide contraceptive services to women of all ages, $4.40 is saved as a result of averting expenditures on medical care, welfare, and nutrition programs in the two years following a birth.[51] The same methodology applied to the state of California yielded even more dramatic results: a savings of $7.70 for every dollar spent on contraceptive services.[52] Similiarly, hearings before the New York City Council revealed that for every dollar spent by the city on teenage pregnancy prevention, at least $3 is saved in health and welfare costs.[53]

However the economic costs of teen pregnancy extend far beyond the short-term expenditures measured in the studies cited above. Pregnant teenagers face health risks, academic failure and a potential lifetime of poverty. During pregnancy, teenagers are at a much higher risk of suffering from serious medical complications, including anemia, pregnancy-induced hypertension (toxemia), cervical trauma and premature delivery than older women. For very young girls (under the age of 15), the maternal mortality rate is 60 percent greater than it is for women in their twenties.[54]

The babies of teenage mothers are more likely to be born with a low birthweight and to suffer subsequent ill health than the children of older women. The babies of 15- to 19-year-olds are a third again as likely to be born with a low birthweight as the babies of women who delay childbearing; infants born to girls under the age of 15 are almost twice as likely to suffer from low birthweight.[55] Moreover, the infants born to teenagers under 18 are almost twice as likely to die in the first year of life as babies born to women over the age of 20.[56] Prenatal care received throughout pregnancy greatly reduces the chances that a woman will deliver a baby with a low birthweight. Yet in 1988 only half of all pregnant teenagers began prenatal care in their first trimester, compared with 85 percent of older women, and four percent received no prenatal care at all.[57]

Low birthweight and infant morbidity place significant economic burdens on families and on the nation's health care system. Yet the costs and consequences of teen pregnancy extend beyond the maternity ward. Children born with a low birthweight suffer more chronic health conditions, require more hospitalization, and are generally in poorer health throughout childhood than children born with a normal birthweight.[58] The children of teenage mothers, often raised in single-parent households, are at a disadvantage throughout life. They are more likely to experience problems in school, to attain less education, and to live in poverty as adults than are children born to women who delay parenting.[59]

Too often, an early birth leads a woman and her family into a spiral of truncated education and subsequent public dependency. Too-early childbearing increases dramatically a woman's chance of living in poverty, which in turn increases the chance of her children becoming teenage parents and living in poverty. Welfare support and other public programs are essential to helping these young families, but

studies have shown that if the pregnancies were delayed just a few years the chance of a woman depending on welfare goes down substantially.[60]

According to estimates based on data from the National Longitudinal Survey of Young Women, for each year a first birth is delayed, family income at age 27 increases by almost $500. The woman's individual income is raised by $200. What's more, delaying a birth just until age 18 or 19 raises potential family income by close to $700. This means that for each year a first birth is delayed (until age 20), the chance of a woman and her family living below the poverty level is reduced by about 22 percent.[61]

What are the factors that lead teen parents into the cycle of poverty, or at least into reliance on public support of some kind? The first is the effect of teen pregnancy on education. Although more adolescent mothers than ever are completing high school, their educational disadvantage persists since all women are completing more years of schooling. By the mid-1980s the number of adolescent mothers completing high school had tripled from the 1950s, from 19 percent in 1958 to 56 percent in 1986. Yet, the high school completion rate for all women rose more than 25 percent in the same period, from 70 to 89 percent.[62] Even as high school graduation rates improve, 40,000 girls continue to drop out of school each year because of teen pregnancy.[63] Research has repeatedly demonstrated that women who bear children as teenagers and drop out of school are substantially less likely ever to go back to school and complete their education than those who delay parenting until after high school.[64] Without a high school degree, these young mothers face limited job opportunities and diminished earning potential. Many confront a lifetime of poverty; families begun by teenage mothers comprise more than half of all AFDC recipients.[65]

A number of factors conspire to make it difficult for women who become mothers as teenagers to achieve economic independence after an early birth. An average of 51 percent of adult recipients of AFDC did not finish high school.[66] These women are three times less likely to leave welfare through work than women who graduate high school. A high school education also increases the chances that a woman will marry and leave welfare—high school graduates are two-and-a-half times more likely to leave welfare through marriage than high school dropouts.[67] Marriage or the attainment of adulthood by the dependent

child remain the most common avenues to leaving AFDC. Only one in five single mothers who leave AFDC is able to do so through her increased earnings.[68]

The effects of a curtailed education are compounded by the fact that women who have children early have more children more rapidly than women who delay childbearing.[69] Teenage mothers are also likely to experience repeat unintended pregnancies, whether due to inadequate contraceptive use or a generalized failure to plan childbearing.[70] Each child born to a teenage mother increases the burden of public support.

One out of every ten teenage girls becomes pregnant every year in the United States;[71] 84 percent of these pregnancies are unintended.[72] How can we help teenagers avoid unintended pregnancy and the consequences of too-early childbearing? The answers are complex and multilayered, requiring a broad array of strategies and programs, and cooperation among disparate groups—parents, teachers, policy-makers, corporations, schools, clinics and religious institutions—who all share the common goal of improving adolescents' futures.

The approach of the last decade, promoted by the Reagan and Bush administrations and implemented through Title XX of the Public Health Services Act, the Adolescent Family Life Act, has centered on abstinence from sexual intercourse. Yet, data from the 1988 National Survey of Family Growth, along with the rising teen birth rate reported by the National Center for Health Statistics, suggest that more teens are becoming sexually active at earlier ages. The percentage of sexually active 15- to 19-year-old women rose from 43 percent in 1982 to 51 percent in 1988, an increase of about 20 percent.[73] Sexual activity rates among 17- to 19-year-old males rose by 15 percent from 1979 to 1988.[74] Today, four out of five teens are sexually active by age 20.[75] Teens do not seem to be postponing sexual activity; rather, more are becoming sexually active at even younger ages. At risk of experiencing sexually transmitted disease and pregnancy, these teenagers are in desperate need of reproductive health care services, including contraception. Many are also in need of better education, comprehensive health care, employment training and expanded economic opportunities.

Too-early childbearing is a burden that weighs most heavily on the lives of young mothers, their children and their families. Yet its costs to society—both measurable and unmeasurable—are no less great. Nor are they acceptable. We can no longer afford to let our youth stumble into

parenting, a course that should be embarked on only when one is ready, willing and able to become a parent. By building an extended network of services and programs–sound schooling and job skills training, outreach to at-risk youth, family planning counseling including support for delaying sexual activity, access to contraception, and medical services including safe, legal abortion for teens who choose not to continue a pregnancy–we can enable teenagers to chart better, more secure futures for themselves.

Pregnancy Prevention Efforts In The States

While teenage pregnancy is a dilemma for the nation as a whole, the bulk of prevention efforts occurs on a more local level. State policies can affect teen pregnancy and parenting in a number of ways: how much financial support is provided to teen mothers on welfare, what kind of health care and social services are available to pregnant adolescents, whether education and job-training programs are in place for at-risk youth and parenting teens, and, most importantly, whether adequate attention is paid to the provision of primary prevention services—education, sex education, and family planning services—to at-risk children and adolescents.

- Since 1985, two-thirds of the states have improved their organizational approach to teen pregnancy and parenting by such efforts as coordinating programs and services, expanding support for individual agencies, and forming task forces to plan initiatives aimed at reducing the incidence of too-early childbearing.[76]
- Seventeen states have coordinated programs and policies for teen pregnancy prevention.[77]
- Twenty-three states (including the District of Columbia) require the provision of sexuality education; another 23 officially encourage it.[78]
- Two-thirds of the states require or encourage schools to teach about pregnancy prevention.[79]
- Twenty-six states have statewide programs to reduce school failure among secondary school youth.[80]
- At least twelve states provide financial support for school-based clinics.[81] Four states provide policy guidelines that are helpful to local school boards in establishing SBCs.[82]
- Twenty-five states provide funds totalling more than $1 million per year for non-Meidicaid family planning services for women of all ages.[83]
- Fifteen states provide Medicaid coverage for pregnant women and children up to 185 percent of the federal poverty level. Four states provide coverage up to 150 percent of the federal poverty level.[84]

5. Methodology

Calculating the Costs

The costs of teenage childbearing have been conceptualized in three different ways. The first is in terms of expenditures in a given year: **single year cost**. This figure answers the question: "In 1989, how much did the federal government spend on families begun when the mothers were teenagers?" This includes public outlays for families currently headed by teenage mothers and also those in which the mother is now 20 years of age or older, but had her first child when she was still in her teens. Although the vast majority of AFDC families have a single, female head-of-household, CPO calculations do not distinguish between married and unmarried teen mothers.

CPO includes three forms of public assistance in the calculation of these costs: Aid for Families with Dependent Children (AFDC), Medicaid, and Food Stamps. The dollar value includes both direct payments to individuals, as well as the administrative and service costs of these programs. Costs of social service programs for young mothers, special education, foster care, and public housing subsidies are not included in the single year cost. Though some of these expenditures are clearly attributable to teenage childbearing, estimating the dollar amounts on a national level for all families begun by a teen birth is not feasible.

The second type of cost is the projected cost over 20 years of a single teen birth in a given year: **single birth costs**. This figure answers the question: "How much will a family begun in 1989 by a teen birth cost the public by the time that first baby is twenty years old?" This number may appear low because it is an average cost based on the total estimated number of first births to all teen mothers in 1989. Because approximately one-third of teenage mothers receive public assistance, the actual cost for a family requiring public assistance and begun by a teen birth in 1989 will be about three times this estimated average cost.

The single birth costs are adjusted to reflect two important trends. First, the probability of receiving public assistance decreases over a teen mother's lifetime. The probability that a teen mother will receive welfare is one in three (.34), and the average length of time a woman who begins her family as a teen receives that assistance is 2.5 years. By the time a teen mother is 30 years old, the probability that she will still be receiving public assistance decreases to less than three in one hundred (.03).

Second, those who begin childbearing earlier in their teen years are likely to have more children than those who delay childbearing. Teens who have their first child before age 18 will have, on average, 3.2 children by age 32. Those who delay childbearing until they are 18 or 19 years old will have an average of 2.8 children by the time they reach age 32. These estimates are important in projecting the number of family members eligible for benefits and future medical expenses associated with pregnancy and childbearing.

The third type of cost calculated is the projected 20-year cost of all first children born to teens in a given year: **single cohort costs**. In this case we are answering the question, "How much will all the families begun by a teen birth in 1989 cost by the time those first babies are twenty years old?" This is calculated by multiplying the single birth costs for 1989 by the total number of first births to teens in that year. For both single birth cost and single cohort cost estimates, social service and public housing costs are included, in addition to AFDC, Medicaid, and food stamp costs used to calculate single year costs.

For all the public costs calculated, an estimate is made of the potential savings to the public had there been no births to teenagers in 1989, or in other words, what we might still expect to spend had all those teen births been prevented. The potential savings are lower than the public costs in each case because delaying childbearing until age 20 or older does not guarantee that a woman will never need to receive public assistance. Because many of the women who become teenage mothers are already at a higher risk of needing financial assistance as an adult, many of the costs included in these calculations would be reduced by eliminating teenage births, but they could not be eliminated entirely. Previous research into public costs of teenage childbearing estimated a savings rate of 20 percent for reducing teenage births by half.[85] Thus, CPO determines potential savings for delaying 100 percent of teen births by figuring 40 percent of the calculated public costs.[86]

Determining Public Outlays*

The cost of AFDC payments attributable to families begun by teen births is calculated as 53 percent of the total AFDC payments made in 1989. This estimate is based on extensive computer simulations, with a variety of databases, that resulted in a range of 50 percent to 56 percent of total AFDC expenditures. CPO settled on the midpoint of 53 percent for the purposes of this study, allowing for the possibility that the actual amount may be very slightly higher or lower. Administrative costs are estimated at 12 percent of direct costs, based on national averages over a five-year time period.

Medicaid payments are determined from the average yearly payments for adults and children and the monthly average number of adults and children receiving these payments because of their AFDC eligibility, multiplied by 53 percent. Administrative costs for Medicaid are calculated as 5 percent of the direct payments, again based on national averages over a five-year time period.

Food stamp costs are determined from the average monthly payment (multiplied by 12) and the monthly average number of adults and children receiving food stamps, multiplied by 53 percent. Administrative costs for food stamps are estimated as 12 percent of direct costs.

For single birth and single cohort costs, both married and unmarried teens experiencing a first birth in 1989 are included. A teen mother who is married has a higher probability of needing public assistance during the first twenty years of her child's life than does a married teen who delays childbearing until she is 20 or more years old.

CPO focused on teens having first births because the first teen birth often triggers a sequence of events necessitating public assistance. Subsequent births are accounted for in the 53 percent calculation of welfare families begun by a teen birth and in the calculation of single birth and single cohort costs that include costs over a 20-year period. In considering costs over the next 20 years, it should also be noted that these costs are discounted at a rate of 4 percent. This assumes that a dollar invested in 1989 will grow at an interest rate of 4 percent (after inflation) per year, compounded annually.

*See also section on Sources of Data, p.36.

6. Sources Of Data For 1989 Costs

Single Year Public Costs Estimates

AFDC Expenditures: $17,244,000,000 in AFDC direct cash grants, Fiscal Year (FY) 1989.[87] Administrative costs of $2,435,800,000 added for total AFDC expenditures.[88]

Food Stamp Expenditures: $51.90 average monthly Food Stamp payment per individual in FY 1989.[89] Multiplied by 10,935,483, the average monthly number of adults and children receiving AFDC in FY 1989.[90] Adjusted for an 84.6 percent participation rate of AFDC households in the food stamp program.[91] Administrative expenses of 12 percent added.[92]

Medicaid Expenditures: 5,717,380 AFDC adults and 10,318,231 AFDC children received a total of $6,896,514,466 (to adults) plus $6,891,884,116 (to children) during FY 1989.[93] Administrative expenses of 5 percent were added based on recent actual experience.[94]

Single Birth and Single Cohort Public Costs Estimates

AFDC Cost: An average payment of $131 per recipient per month in FY 1989.[95] AFDC benefits are adjusted at a rate of 3.2 percent per year to account for inflation and discounting.[96]

Food Stamp Cost: $51.90 was the average payment per recipient per month in 1989.[97] For the years following 1989, the per recipient cost was reduced by 3 percent per year (5 percent inflation minus 2 percent increase in food stamp allocation). All adjusted for a 84.6 percent participation rate of AFDC households in the food stamp program.[98] Administrative costs of 12 percent added.[99]

Annual Medicaid Cost: On average each AFDC child cost Medicaid $668 in FY 1989, while each adult cost Medicaid $1,206.[100] These numbers remain constant for the 20-year projections because costs will keep pace with inflation.

First Births: In 1988 there were 10,234 births to girls under 15; 151,280 births to 15- to 17-year-olds, and 212,793 births to 17- to 19-year-olds. 1988 natality statistics were used to estimate 1989 births, as these are the latest available.[101]

Medicaid Costs Associated with Births: These calculations used $3,494 as the cost borne by Medicaid (including prenatal care costs) for a birth to a teenager 14 or younger; $3,224 as the cost for 15- to 17-year-olds, and $2,696 as the cost for 18-19 year-olds. These figures are the average costs estimated by three different studies: Walentik,[102] Wertheimer and Moore,[103] and Burt et al.,[104] adjusted for inflation at 4 percent per year since 1985.

Social Service Cost: Assumed to be 5 percent of AFDC cost, following Walentik's logic and example.[105]

Public Housing Cost: Assumed to be 2 percent of AFDC cost, following Walentik's and SRI International's examples.[106]

AFDC, Food Stamp and Medicaid Administrative Costs: AFDC administrative costs of $2,435,800,000.[107] Food Stamp administrative costs calculated using 12 percent of direct benefits, based on historical precedent.[108] Medicaid administrative costs calculated at 5 percent of benefits, also based on historical precedent.[109]

Single Year Public Cost Estimates for the States and Cities

Vermont

AFDC Expenditures: $40,885,847 in AFDC direct cash grants FY 1989. Administrative expenses of $5,115,215 added for total AFDC expenditures.[110]

Food Stamp Expenditures: $51.90 average monthly food stamp payment per individual in FY 1989.[111] Multiplied by 32,339, the average monthly number of adults and children receiving AFDC in FY 1989. Adjusted for 86 percent participation rate of AFDC households in the food stamp program.[112] Administrative costs of 12 percent added.[113]

Medicaid: 5,463 AFDC adults and 7,984 AFDC children received a total of $7,671,297 (to adults) and $4,685,806 (to children) during FY 1989.[114] Administrative expenses of 5 percent added.[115]

Louisiana

AFDC Expenditures: $184,098,108 in AFDC direct cash grants FY 1989. Administrative costs of $22,572,807 added for total AFDC expenditures.[116]

Food Stamp Expenditures: $51.90 average monthly food stamp payment per individual in FY 1989.[117] Multiplied by 275,094, the average monthly number of adults and children receiving AFDC in FY 1989. Adjusted for 73 percent participation rate of AFDC households in the food stamp program.[118] Administrative expenses of 12 percent added.[119]

Medicaid Expenditures: 101,292 AFDC adults and 274,428 AFDC children received a total of $150,852,898 (to adults) and $166,778,958 (to children) during FY 1989.[120] Administrative expenses of 5 percent were added.[121]

Wisconsin

AFDC Expenditures: $432,524,874 in AFDC direct cash grants FY 1989. Administrative costs of $43,904,090 added for total AFDC expenditures.[122]

Food Stamp Expenditures: $51 average monthly food stamp payment per individual in FY 1989. Multiplied by 237,755, the average monthly number of adults and children receiving AFDC in FY 1989. Adjusted for an 85 percent participation rate of AFDC households in the food stamp program.[123] Administrative costs of 12 percent added, based on national estimates.[124]

Medicaid Expenditures: 81,894 AFDC adults and 153,152 AFDC children[125] received a total of $98,764,194 (to adults) plus $102,305,536 (to children) during FY 1989.[126] Administrative expenses of 5 perecent were added.[127]

New Mexico

AFDC Expenditures: $54,962,877 in AFDC direct cash grants, fiscal year (FY) 1989. Administrative costs of $10,741,174 added for total AFDC expenditures.[128]

Food Stamp Expenditures: 57,581 AFDC recipients received a total of $28,406,088 in benefits in FY 1989.[129] Administrative expenses of 12 percent added.[130]

Medicaid Expenditures: 20,894 AFDC adults received a total of $29,247,019 and 41,225 AFDC children received a total of $23,366,667 during FY 1989. Administrative expenses of 3 percent were added.[131]

Oregon

AFDC Expenditures: $136,548,525 in AFDC direct cash grants FY 1989. Administrative costs of $42,287,221 added for total AFDC expenditures.[132]

Food Stamp Expenditures: $57.12 average monthly food stamp payment per individual in FY 1989. Multiplied by 79,582, the average monthly number of adults and children receiving AFDC in FY 1989. Adjusted for an 80 percent participation rate of AFDC households in the food stamp program.[133] Administrative expenses of 12 percent added.[134]

Medicaid Expenditures: 27,985 AFDC adults and 60,856 AFDC children received a total of $28,021,660 (to adults) and $31,192,960 (to children) during FY 1989.[135] Administrative costs of 5 percent added.[136]

Baltimore

AFDC Expenditures: $150,509,608 in AFDC direct cash grants, FY 1989.[137] Administrative costs of $18,061,153 added for total AFDC expenditures.[138]

Food Stamp Expenditures: $62.14 average monthly food stamp payment per individual in FY 1989.[139] Multiplied by 101,706, the average monthly number of adults and children receiving AFDC in FY 1989.[140] Adjusted for 76 percent participation rate of AFDC households in the food stamp program.[141] Administrative costs of 12 percent added.[142]

Medicaid Expenditures: 37,983 AFDC adults and 85,518 AFDC children[143] received a total of $52,910,319 (to adults) and $62,941,248 (to children) during FY 1989. Administrative costs of 2.2 percent were added.[144]

St. Louis

AFDC Expenditures: $56,273,500 in AFDC direct cash grants, FY 1989. Administrative costs of $6,752,820 (estimated at 12 percent of benefits) added for total AFDC expenditures.[145]

Food Stamp Expenditures: $57.03 average monthly food stamp payment per individual in FY 1989. Multiplied by 55,774, the average monthly number of adults and children receiving AFDC in FY 1989.[146] Adjusted for 84.6 percent participation rate of AFDC households in the food stamp program.[147] Administrative expenses of 12 percent added.[148]

Medicaid Expenditures: 11,305 AFDC adults and 15,694 AFDC children received a total of $19,071,535 (to adults) and $32,204,088 (to children) during FY 1989.[149] Administrative costs of 5 percent added.[150]

7. Endnotes

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[3]The Alan Guttmacher Institute (AGI), *Teenage Pregnancy in the United States: the Scope of the Problem and State Responses*, New York, 1989. 45 percent of pregnancies to 15- to 19-year-olds result in live births; 42 percent end in abortion, and 13 percent end in miscarriage or stillbirth.

[4]F.F. Furstenberg, J. Brooks-Gunn, and S.P. Morgan, "Adolescent Mothers and Their Children in Later Life," *Family Planning Perspectives*, 19:4, July/August 1987.

[5]NCHS, "Advance Report," see reference 1.

[6]M.R. Burt, "Estimates of Public Costs for Teenage Childbearing," Center for Population Options: Washington, D.C., 1986. See also R.F. Wertheimer and K.A. Moore, *Teenage Childbearing: Public Sector Costs*, The Urban Institute: Washington, D.C., 1982, Final Report on Contract No. N01-HD092822, submitted to the Center for Population Research, NICHD.

[7]Ibid.

[8]NCHS, "Advance Report," see reference 1.

[9]Burt, see reference 6.

[10]Ibid.

[11]Ibid.

[12]AGI, see reference 3.

[13]E. Jampol, *Report of the Governor's Task Force for Prevention of Teen Pregnancy, 1988*, Vermont Agency of Human Services, 1989.

[14]R.G. Diamond, *A Better Future for Vermont Teens: Report of the Governor's Task Force for Prevention of Teen Pregnancy, 1987*, Vermont Agency of Human Services, 1988.

[15]Jampol, see reference 13.

[16]Burt, see reference 6.

[17]Ibid.

[18]AGI, see references 3.

[19]Unpublished data from the Louisiana Family Planning Program, Department of Health and Hospitals.

[20]Personal communication between author and P. Braxton, State of Louisiana, Department of Social Services, July 30, 1990.

[21]Burt, see reference 6.

[22]Ibid.

[23]AGI, see reference 3.

[24]R. Sweet, L. Rose and V. Ellis, "Overview of Teenage Pregnancy and Pregnancy Prevention: Staff Brief 90-10," Wisconsin Legislative Council Staff: Madison, August 31, 1990.

[25]Ibid.

[26]Burt, see reference 6.

[27]Ibid.

[28]AGI, see reference 3.

[29]Personal communication between author and J. Culbertson, New Mexico Health and Environment Department, July 6, 1990.

[30]D. deMauro, "Sexuality Education 1990: A Review of State Sexuality and AIDS Education Curricula, *SIECUS Report*, 18:2, December 1989/January 1990.

[31]Personal communication between author and J. Culbertson, see reference 29.

[32]"Teen Pregnancy in Oregon: A Search for Answers. Executive Summary," preliminary report from the House Bill 3114 Committee on Adolescent Pregnancy and Parenthood, June 1990.

[33]Burt, see reference 6.

[34]AGI, see reference 3.

[35]"Teen Pregnancy in Oregon," see reference 32.

[36]AGI, see reference 3.

[37]"Teen Pregnancy in Oregon," see reference 32.

[38]Ibid.

[39]Approximation from S. Zuravin, University of Maryland School of Social Work.

[40]Burt, see reference 6.

[41]Provisional data from Bureau of Information Resource Management, Vital Statistics, Baltimore City.

[42]"Adolescent Sexual Activity, Pregnancy and Childbearing," Governor's Council on Adolescent Pregnancy, Fact Sheet, Series 1, No. 2, September 1988.

[43]Personal communication between author and J. Santelli, Baltimore City Health Department, July 20, 1990.

[44]Burt, see reference 6.

[45]Ibid.

[46]Missouri Department of Health, State Center for Health Statistics, "Missouri Vital Statistics, 1988," Table 10B, Jefferson City, Missouri.

[47]Personal communication between author and D. Page, Planned Parenthood of the St. Louis Region, Sepember 1990.

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[49]AGI, see reference 3.

[50]F. Wattleton, "Teenage Pregnancies and the Recriminalization of Abortions," *American Journal of Public Health*, 80:3, March 1990.

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The Center for Population Options (CPO) is a nonprofit educational organization dedicated to improving the quality of life for adolescents by preventing too-early childbearing.

CPO's national and international programs seek to improve adolescent decision-making through life planning and sexuality education programs. As part of its mission, CPO promotes access to comprehensive health care, including family planning, through school-based and other community-based clinics and works to prevent the spread among adolescents of HIV and other sexually transmitted diseases.

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